DEPARTMENT OF HUMAN SERVICES

SENIORS & PEOPLE WITH DISABILITIES
500 Summer Street NE E02
Salem, Oregon 97301-1073
Phone: (503) 945-5811

AUTHORIZED BY: _____
SPD Assistant Director/
Deputy Assistant Director

EXECUTIVE LETTER
SPD-EL-03-009
Date: February 10, 2003

TO:

Area Agency on Aging Directors
CHS/AAA Field Managers and Staff
SPD Managers & Staff
CHS SDA Managers
CHS SDA Assistant Managers
CHS Central Office Managers

SUBJECT: **Skilled Nursing Facility Coverage for New Clients Placed on or after February 1, 2003**

ADMINISTRATIVE RULE REFERENCE:

Topic:	N/A
Rule Number:	N/A
Filing Instructions:	N/A

PURPOSE:

___ Transmits new or amended Administrative Rule;
___ Interprets Administrative Rule;
_X_ Establishes procedures related to Administrative Rule;
___ Replaces existing procedures or interpretation;
___ Deletes Administrative Rule.

GROUND TRUTHED: ___ Yes _X_ No

EFFECTIVE DATE: Upon receipt **EXPIRATION DATE:** N/A

DATE SENT FOR COMMENTS TO DIRECTORS AND MANAGERS:

DISCUSSION:

With all of the changes effective February 1, 2003, many questions have surfaced around eligibility for skilled nursing facility coverage. The policy supporting this information memo is not new. However, these questions have come to the forefront because:

- ✧ The Oregon Health Plan (OHP) now has the OHP-Plus and OHP-Standard benefit packages with different levels of coverage, and
- ✧ The Department no longer provides services to clients assessed at survivability priority levels 15-17.

This information memo is only addressing clients who are placed in a skilled nursing facility on February 1, 2003 or after.

OHP-Standard

Under the OHP-Standard benefit package, clients are eligible for hospital services. Part of the hospital services benefit includes up to 20 days for recovery in a skilled nursing facility. Because this is part of the hospital coverage, the copay paid for the hospital services also covers the skilled nursing facility and no additional copay is charged. This benefit is handled one of two ways:

- ✧ For clients in managed care plans, the health plan authorizes placement and payment for skilled nursing facility care not to exceed 20 days. These clients do not have a long term care file.

- ✧ For clients in fee for service, the Pre-Admission Screening (PAS) specialist authorizes the placement and payment for these skilled nursing facility services. The case manager opens the long term care file with an NH level of care code, for a period not to exceed 20 days.

OHP-Plus

Only clients eligible for OHP-Plus are eligible for skilled nursing facility coverage beyond the 20 days. To be eligible, all of the following must be met:

- ✧ These clients must have their service priority level assessed, and fall within the service levels currently being served by the Department. Currently, the service levels being served are levels 1-14. Further program cuts are planned which will reduce the service levels being served to 1-9 effective April 1, 2003.

- ✧ These clients must be categorically eligible for Medicaid. In other words, they must be eligible for medical programs such as TANF, OSIP or OSIPM, or be pregnant females and children with income less than 185% of the federal poverty level, etc.

- ✧ In order to be determined eligible for OSIPM, clients under age 65 who have not been determined disabled by Social Security Administration (SSA) criteria must have a

presumptive Medicaid disability determination in order to verify that they meet the disability criteria. Only after the Presumptive Medicaid Disability Determination Team (PMDDT) has allowed the disability, can a long term care file be established for these clients.

Note: Many OSIPM clients also have Medicare coverage, in addition to OHP-Plus. Medicare provides coverage for skilled nursing facility care up to 100 days. The first 20 days runs concurrently with OHP-Plus and the long term care file is coded Z EC. For day 21 through 100, the long term file is coded V EC. If the OHP-Plus client is decertified to an ICF level of care, the long term care file should be revised.

Impact on Providers

Because clients receiving the OHP-Standard benefit package are admitted to the hospital and only qualify for 20 days of skilled nursing facility care upon discharge, nursing facilities are understandably concerned about accepting these clients for care. The skilled nursing facility is only guaranteed payment for the client's care for up to 20 days. Federal and State rules will not allow the skilled nursing facility to discharge the client at the end of the 20 days if it is not safe to do so. Many clients will not meet the presumptive Medicaid disability criteria. These clients often do not have a disability that will last at least a year or have a disability of the severity required under SSA criteria. The skilled nursing facilities are concerned that it will be difficult to get a disability determination within 20 days, even for clients who do meet the durational and severity requirements. Consequently, DHS may encounter resistence from nursing facilities in accepting the same clients upon discharge that they have in the past.

What You Can Do

Clients on OHP-Standard who are authorized for only 20 days of skilled nursing facility care must be quickly evaluated. If it appears the client will need this level of care for longer than 20 days, consider the OHP Hospice Benefit or review EL-03-008 and IM-03-014 to determine whether the case should be referred to the PMDDT for decision. If a referral is appropriate, forward the required documents and contact Lisa Zacharias at (503) 945-5678 to alert the team to the urgency of the decision.

CONTACT:	Sharon Gilles - PMDDT policy	**PHONE:**	(503) 945-6373
E-MAIL:	sharon.l.gilles@state.or.us	**FAX:**	(503) 373-7902
CONTACT:	Keith Ramey - nursing facility policy	**PHONE:**	(503) 945-6407
E-MAIL:	keith.r.ramey@state.or.us	**FAX:**	(503) 373-7902

LOCAL ACTION REQUIRED:

Review this transmittal upon receipt.

CENTRAL OFFICE ACTION REQUIRED:

Render decisions on cases referred to PMDDT.

TRAINING EXPECTATIONS:

No training is planned on this issue.